COPD Care Map for Primary Care
Follow-Up Assessment

☐ N/A

Date YYYY/MM/DD | Visit ☐ Scheduled ☐ Unscheduled

Referring health care provider | Healthcare Professional Role Type e.g respirologist

Provider identifier assigning authority e.g Regulatory body for physicians & surgeons | Provider Identifier Type e.g provider billing number

Reason for referral

☐ New COPD Diagnosis ☐ Suspected COPD

☐ Other

Demographics ☐ N/A

Client Name (please print)

Client Identifier Type e.g Jurisdictional Health Number | Client Identifier Assigning Authority e.g OHIP

Anthropometric Vitals ☐ N/A

Height cm | BMI

Weight kg | Sp02 | _____ L/min

COPD Diagnosis* ☐ N/A

☐ Unknown ☐ Confirmed YYYY/MM/DD Date Confirmed/Excluded (If uncertain indicate "unknown" in the provided field) ☐ Asthma COPD Overlap

☐ Suspected # Age COPD was confirmed ☐ Spirometry attached

*ensure a diagnosis of COPD is made with post-bronchodilator spirometry testing to meet the Canadian Thoracic Society criteria
Post-bronchodilator FEV_1/FVC ratio < LLN or < 0.70

Appointment Type

☐ Scheduled ☐ Yes ☐ No ☐ Post ED Visit ☐ Yes ☐ No

☐ Post Hospital Visit ☐ Yes ☐ No

If yes: ☐ Within 7 days post-hospital visit ☐ Within 14 days post-hospital visit ☐ More than 14 days post-hospital visit

Medications ☐ Unchanged since last visit ☐ N/A

Respiratory Medications	Drug Name	Strength (Unit of Measure)	Dose form (device type)	Route	Rx Date	Adherence issues known or suspected
Short acting β-agonist (SABA)						Yes ☐ No ☐
Short acting muscarinic antagonist (SAMA)						Yes ☐ No ☐
Long acting β-agonist (LABA)						Yes ☐ No ☐
Long Acting Muscarinic Antagonist (LAMA)						Yes ☐ No ☐
Inhaled Corticosteroid (ICS)						Yes ☐ No ☐
LAMA/LABA						Yes ☐ No ☐
ICS/LABA						Yes ☐ No ☐
ICS/LABA/LAMA						Yes ☐ No ☐
Antibiotics						Yes ☐ No ☐
Macrolide						Yes ☐ No ☐
Prednisone						Yes ☐ No ☐
Other						Yes ☐ No ☐
Other						Yes ☐ No ☐
Other						Yes ☐ No ☐

Oxygen Therapy: _____ L/ min at rest _____L/min on exertion _____ L / min during sleep

SABA use ☐ < 1 canister/ month ☐ 1-2 canister/ month ☐ > 1 canister/ month

	Yes	No
Patient has a spacing device	☐	☐
Does at least one prescribed medication allow for a spacing device to be used?	☐	☐
Unfilled prescriptions. In the last 6 months has the patient been prescribed any COPD medications he/she has not obtained.	☐	☐

Past Medications

Yellow Zone Medications

Client Name _____ Jurisdictional Health Number _____

Family History of Lung Disease ☐ N/A

Family History of COPD, Allergy and/or Asthma ☐ Yes ☐ No ☐ Unknown

(If yes select conditions from a list and indicate which relative)

COPD	☐ Parent	☐ Sibling
Allergy	☐ Parent	☐ Sibling
Alpha-1 Antitrypsin	☐ Parent	☐ Sibling
Asthma	☐ Parent	☐ Sibling

Physicial Exam ☐ N/A

☐ Normal breath sounds ☐ Abnormal breath sounds

If abnormal, select auscultory finding

☐ Wheezes ☐ Crackles ☐ Reduced Breath Sounds ☐ Bronchial (harsh and prolonged inspiration and expiration)

☐ Barrel chested ☐ Clubbing ☐ Cachectic

Vitals: HR _____ RR _____ BP _____

Current Symptoms ☐ N/A

Breathlessness ☐ at rest ☐ on exertion

	Yes	No
Chest tightness	☐	☐
Wheeze	☐	☐
Cough	☐	☐
Sputum production	☐	☐
Sputum colour _____		
Sputum consistency _____ Sputum volume _____		
Hemoptysis*	☐	☐
Frequent colds	☐	☐
If yes frequency ☐ 0-3/year ☐ 4-7/year ☐ ≥8/year		
Colds that last longer than 7 days	☐	☐
Symptoms worse at night (including cough)	☐	☐
Chest pain	☐	☐
Limitation of activities at home	☐	☐
Sleep soundly	☐	☐
Decreased energy level	☐	☐

*This symptom must be reported to the client's provider

Smoking ☐ N/A

Smoking Status ☐ Non-Smoker ☐ Ex-Smoker ☐ Smoker (# of cigarettes per day ____)

Quit Date YYYY/MM/DD

Quit Duration

When was the last time you smoked a cigarette, even a puff?

☐ > 6 months ☐ 1-6 months ☐ < 1 month

Passive Smoking Risk

☐ Yes ☐ No

Pack Years

Cig Smoked/day ____ / 20 x Years smoked ____ = Pack years ____

Smoke Type

☐ non-traditional tobacco (e.g. cigarettes/ cigarillo/ cigar)

☐ Cannabis use ☐ e-cigarette user

☐ traditional tobacco (e.g. smudging ceremonies)

☐ Inhalation vapor user ☐ hooka ☐ shisha

Smoking Cessation Quit Intentions

Are you planning to quit smoking?

☐ within a month ☐ within 6 months

☐ beyond 6 months ☐ not planning to quit

Stages of Change Addressed

☐ pre-contemplation ☐ contemplation ☐ preparation

☐ action ☐ maintenance

Smoking Cessation Addressed

☐ Ask ☐ Advise ☐ Arrange

Smoking Cessation Aids

☐ Nicotine Replacement Therapy (NRT)

☐ Prescription medication (e.g., varenicline, bupropion)

COPD Healthcare Utilization ☐ N/A

Visit(s) to primary care physician in the last 12 months for COPD symptoms

☐ Yes ☐ No ☐ Unknown

If Yes, indicate the number of primary care visits for COPD in the last 12 months

Routine primary care visits ____ Urgent primary care visits ____

Visit(s) to a specialist for COPD

	Yes	No	Unknown	Last 12 Months
Respirologist	☐	☐	☐	☐
General Internist	☐	☐	☐	☐
Allergist	☐	☐	☐	☐

	Yes	No	Unknown	Recent < 1yr	Total # ever
ED visits since last visit	☐	☐	☐	☐	
Hospitalized since last visit	☐	☐	☐	☐	

			# ICU admissions	# intubations
ICU admissions since last visit	☐	☐	☐	

			Date last used	Total # ever
Systemic steroid use since last visit	☐	☐	☐	

Barriers ☐ N/A

Barriers ☐ Yes ☐ No (If yes select from the list below)

	Yes	No
Adherence	☐	☐
Cultural issue	☐	☐
Financial issue	☐	☐
Lack of private drug plan	☐	☐
Language	☐	☐
Literacy	☐	☐
Medication side effects	☐	☐
Other ____	☐	☐

Effect of substances addiction ☐ Yes ☐ No

Social/Family issue ☐ Yes ☐ No

Client Name _____ Jurisdictional Health Number _____

Modified Medical Research Council Classification ☐ N/A

- ☐ mMRC 0: I only get breathless with strenuous exertion
- ☐ mMRC 1: I get SOB when hurrying on the level or walking up a slight hill
- ☐ mMRC 2: I walk slower than other people of the same age on the level, or stop for breath when walking at my own pace
- ☐ mMRC 3: I stop for breath after walking 100 meters or after a few minutes
- ☐ mMRC 4: I am too breathless to leave the house or I am breathless when dressing or undressing

CAT Score (https://www.catestonline.org) ☐ N/A

CAT Score	Impact level
5	Upper limit of normal in healthy non-smokers
< 10	Low
10 - 20	Medium
> 20	High
> 30	Very High

CAT Score _____

CTS severity score (symptom burden and the risk of future exacerbations) ☐ N/A

- ☐ Mild: CAT < 10, mMRC 1, No AECOPD*
- ☐ Moderate: CAT ≥ 10, mMRC ≥ 2, Low Risk of AECOPD*
- ☐ Severe: CAT ≥ 10, mMRC ≥ 2, High Risk of AECOPD*

*Patients are considered at **Low Risk of AECOPD** with ≤ 1 moderate AECOPD in the last year (moderate AECOPD is an event with prescribed antibiotic and/or oral corticosteroids), and did not require hospital admission/ ED visit; or at **High Risk of AECOPD** with ≥ 2 moderate AECOPD or ≥ 1 severe exacerbation in the last year (severe AECOPD is an event requiring hospitalization or ED visit).

Triggers and Exposures ☐ N/A

Have there been any changes to your triggers or exposures since last visit ☐ Yes ☐ No

Category If yes select patient reported triggers & exposures from list.	Triggers ☐ Yes ☐ No ☐ Unknown			Exposures ☐ Yes ☐ No ☐ Unknown		
	Yes	No	Unknown	Yes	No	Unknown
Beta Blockers	☐	☐	☐	☐	☐	☐
Cats	☐	☐	☐	☐	☐	☐
Chemicals	☐	☐	☐	☐	☐	☐
Cockroaches	☐	☐	☐	☐	☐	☐
Cold air/ Windy day	☐	☐	☐	☐	☐	☐
Dogs	☐	☐	☐	☐	☐	☐
Dust/Dust mites	☐	☐	☐	☐	☐	☐
Emotion/ Stress	☐	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐	☐
Fireplace/Woodstove	☐	☐	☐	☐	☐	☐
Food allergy	☐	☐	☐	☐	☐	☐
Fumes	☐	☐	☐	☐	☐	☐
Fungi/Mould	☐	☐	☐	☐	☐	☐
Grasses	☐	☐	☐	☐	☐	☐
High humidity	☐	☐	☐	☐	☐	☐
Medications	☐	☐	☐	☐	☐	☐
Outdoor pollution	☐	☐	☐	☐	☐	☐
Perfume/Air fresheners	☐	☐	☐	☐	☐	☐
Pollen	☐	☐	☐	☐	☐	☐
Ragweed	☐	☐	☐	☐	☐	☐
Respiratory Infections	☐	☐	☐	☐	☐	☐
Second hand smoke	☐	☐	☐	☐	☐	☐
Other _____	☐	☐	☐	☐	☐	☐

Occupational History

Has your occupation changed since last visit? ☐ Yes ☐ NO If yes, fill out/click on options below. ☐ N/A

Current Employment Status: Check all the apply.
Note - This includes self-employment and working from home:

☐ Full-Time ☐ Part-Time ☐ Shift work ☐ Modified duties ☐ Off work due to respiratory health ☐ Retired

☐ Other _____ Current Employment_____

Significant work exposure _____

Environmental Controls ☐ N/A

Environmental Control Measures in Place ☐ Yes ☐ No (If Yes, Select patient-reported, control measures in place. Optional: repeat questions for individuals with a secondary home.)

	Yes	No	Suggested		Yes	No	Suggested
Air conditioning in summer	☐	☐	☐	Humidifier in winter (desired target < 50%)	☐	☐	☐
Central or hepa-filter vacuum	☐	☐	☐	Humidifier all year round (desired target < 50%)	☐	☐	☐
Dehumidifier (desired target < 50%)	☐	☐	☐	Non-feather blanket	☐	☐	☐
Dust mite mattress cover	☐	☐	☐	Pets kept out of bedrooms	☐	☐	☐
Dust mite pillow cover	☐	☐	☐	Regular furnace filter change	☐	☐	☐
Removed carpets	☐	☐	☐	Remove pets from home	☐	☐	☐
Heat exchanger	☐	☐	☐	Wash linens in hot water	☐	☐	☐
Heating gas/Oil	☐	☐	☐	Wash pets once a week	☐	☐	☐
Heating electric/Radiator	☐	☐	☐	Wear mask or respirator as needed	☐	☐	☐
Alternative to wood heat (fireplaces, wood stoves, furnaces) or mitigation strategies	☐	☐	☐	Other _____	☐	☐	☐

Client Name _____ Jurisdictional Health Number _____

Comorbidities

Have your co-morbidities changed since last visit? ☐ Yes ☐ No If yes, fill out/click on options below: ☐ N/A

Comorbid Conditions ☐ Yes ☐ No (If yes, select relevant comorbid diagnosis from the list provided)

Respiratory	Yes	No	Unknown
A-1 Antitrypsin deficiency	☐	☐	☐
ASA Reaction	☐	☐	☐
Eczema	☐	☐	☐
Emphysema	☐	☐	☐
Lung Cancer	☐	☐	☐
Chronic Bronchitis	☐	☐	☐
Other Lung Disease	☐	☐	☐
Pleurisy	☐	☐	☐
Pneumonia	☐	☐	☐
Pneumothorax	☐	☐	☐
Pulmonary Edema	☐	☐	☐
Pulmonary Effusion	☐	☐	☐
Pulmonary Embolism	☐	☐	☐
Pulmonary Hypertension	☐	☐	☐

Mental Health			
Anxiety	☐	☐	☐
Dementia/Alzheimer	☐	☐	☐
Depression	☐	☐	☐
Panic Disorder	☐	☐	☐

Metabolic			
Diabetes	☐	☐	☐
Hypothyriodism	☐	☐	☐
Metabolic Syndromes	☐	☐	☐

Cardiovascular	Yes	No	Unknown
Aneurysms	☐	☐	☐
Angina	☐	☐	☐
Aortic Stenosis	☐	☐	☐
Aortic Valve Regurgitation	☐	☐	☐
Arrhythmias	☐	☐	☐
Atrial Fibrillation	☐	☐	☐
Cardiomyopathy	☐	☐	☐
Cerebral Vascular Accident	☐	☐	☐
Coronary Artery Disease	☐	☐	☐
Congestive Heart Failure	☐	☐	☐
Cor Pulmonale	☐	☐	☐
Coronary Artery Bypass Surgery	☐	☐	☐
Deep vein thrombosis	☐	☐	☐
Defibrillator	☐	☐	☐
Heart Disease	☐	☐	☐
High Blood Pressure	☐	☐	☐
Hyperlipidemia	☐	☐	☐
Hypertension	☐	☐	☐
Implantable Cardioverter	☐	☐	☐
Mitral Valve Regurgitation	☐	☐	☐
Myocardial Infarction	☐	☐	☐
Myocarditis	☐	☐	☐
Pacemaker	☐	☐	☐
Pedal Swelling	☐	☐	☐
Peripheral Vascular Disease	☐	☐	☐
Syncope	☐	☐	☐
Transient Ischemic Attack	☐	☐	☐

Upper Airways	Yes	No	Unknown
Anaphylaxis	☐	☐	☐
Nasal Polyps	☐	☐	☐
Oral Thrush	☐	☐	☐
Rhinitis/ Sinusitis	☐	☐	☐
Sleep Apnea	☐	☐	☐
Upper Respiratory Tract Infection	☐	☐	☐

Other			
Arthritis	☐	☐	☐
Cancer	☐	☐	☐
Cataracts/Glaucoma	☐	☐	☐
Frequent Colds	☐	☐	☐
GERD	☐	☐	☐
Heartburn	☐	☐	☐
Kidney Disease	☐	☐	☐
Liver Disease	☐	☐	☐
Osteopenia/ Osteoporosis	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐

Other

COPD Action Plan

☐ N/A

	Yes	No	
Written COPD action plan provided	☐	☐	YYYY/MM/DD
Written COPD action plan revised	☐	☐	YYYY/MM/DD
COPD action plan reviewed & not changed	☐	☐	YYYY/MM/DD
Yellow or red zone of action plan followed,	☐	☐	# of Times

Pulmonary Function Test

☐ N/A

Spirometry	LLN	PRE		POST	
	Actual	Actual	% Pred	Actual	% Pred
FVC	L/Min	L/Min	%	L/Min	%
FEV1	L/Min	L/Min	%	L/Min	%
FEV_1 / FVC	L/Min	L/Min	%	L/Min	%
PEF					

DLCO ☐ Yes ☐ No ☐ N/A Results _____

Additional Notes

Client Name _____ Jurisdictional Health Number _____

Immunizations ☐ N/A

	Yes	No	Unknown
Immunizations discussed	☐	☐	☐
Influenza vaccination received	☐	☐	☐

Date of last influenza vaccination YYYY/MM/DD

Conjugated vaccine (PNEU-C-13) YYYY/MM/DD

Polyvalent Pneumococcal vaccine YYYY/MM/DD

https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci.html

Investigations ☐ N/A

Chest CT ☐ Yes ☐ No Results _____

Bone Mineral Density Test (BMD Test)

Date of last YYYY/MM/DD Results g/cm²

Other (past disgnostics)

Alpha-1 Antitrypsin blood work done ☐ Yes ☐ No ☐ N/A

Results _____

ABG on room air done and date (consider when FEV_1 < 40% or resting Sp02 < 90%) ☐ Yes ☐ No ☐ N/A Date of last YYYY/MM/DD

Results: pH ____ PO2 ____ PC02 ____ HC03 ____ Sa02 ____

6 minute walk test ☐ Yes ☐ No ☐ N/A Results _____

Referrals ☐ N/A

	Yes	No	Suggested
Allergist	☐	☐	☐
COPD Education Program/ CRE	☐	☐	☐
Respirologist	☐	☐	☐
Smoking cessation counselling/support	☐	☐	☐
Dietitian	☐	☐	☐
Mental health counselling	☐	☐	☐
Sleep study	☐	☐	☐
Allergy testing	☐	☐	☐
Home O2 assessment	☐	☐	☐
ABGs	☐	☐	☐
Social Worker	☐	☐	☐
Pharmacist	☐	☐	☐
Full PFT testing	☐	☐	☐
Pulmonary Rehabilitation	☐	☐	☐
OTN tele-monitoring program (if available)	☐	☐	☐
Other specialist _____	☐	☐	☐

Follow-up Visit Scheduled in (time frame from current visit) ☐ N/A

☐ 1 Week ☐ 1 Month ☐ 4-6 Months Other _____

☐ 2 Weeks ☐ 2 Months ☐ 6-12 Months

☐ 3 Weeks ☐ 3 Months ☐ "Wait and see"

Education Interventions ☐ N/A

Education provided at this visit ☐ Yes ☐ No

(Identify education provided by selecting from the list below)

	Yes	No		Yes	No
Adherence to medications	☐	☐	Immunotherapy	☐	☐
Barriers addressed	☐	☐	Inhaler technique	☐	☐
COPD Action Plan	☐	☐	Medications	☐	☐
COPD pathophysiology	☐	☐	Provide patient education materials	☐	☐
Coping strategies addressed	☐	☐	Self management goal	☐	☐
Device technique optimal	☐	☐	Smoking cessation	☐	☐
Early recognition & treatment of exacerbations	☐	☐	Triggers & environmental controls	☐	☐
Environmental tobacco smoke exposure	☐	☐	Other _____	☐	☐
Exercise	☐	☐			

Patient understanding of education/Information provided at this visit ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Additional Notes/ Plan

Healthcare Professional Role Type _____ Signature _____